Movement Disorders Post-Field Test Refinement (PFTR) Meeting Summary

MACRA Episode-Based Cost Measures: Clinician Expert Workgroups
Workgroup Webinar, March 26, 2024
April 2024

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Project Overview

The Centers for Medicare & Medicaid Services (CMS) has contracted with Acumen, LLC to develop episode-based cost measures for potential use in the Merit-based Incentive Payment System (MIPS) to meet the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Acumen's measure development approach involves convening clinician expert panels to provide input in cycles of development ("Waves").[1] In Wave 6, we reviewed feedback from prior Waves; this includes input from public comment periods in which we sought input on candidate clinical areas and episode groups for potential development.[2] We developed prioritization criteria used to identify strong candidate episode groups and concepts based on input from our technical expert panel (TEP), Person and Family Engagement (PFE), Clinical Subcommittees (CS), and Clinician Expert Workgroups ("workgroups"). The following Wave 6 episode groups were selected for development based on the prioritization criteria, prior input received, and discussions with CMS: (i) Movement Disorders: Parkinson's and Related Conditions, Multiple Sclerosis [MS], Amyotrophic Lateral Sclerosis [ALS], and (ii) Non-Pressure Ulcers.

We held a nomination period for workgroup members between May 15, 2023, and June 2, 2023. The workgroups are composed of clinicians with expertise directly relevant to the selected episode groups. We finalized workgroups of about 15-20 members in June 2023, and they provided detailed input on the development of the selected episode groups during their first workgroup webinars from June 27 to 28, 2023. Acumen convened the workgroups again for a Service Assignment and Refinement (SAR) Webinar to revisit the specifications recommended

[1] For information on measure development in Wave 6, refer to the Wave 6 Measure Development Process (PDF, 599KB) document (https://www.cms.gov/files/document/2024-02-cmft-ebcm-process.pdf).
[2] For a summary of comments we received during the Waves 4 and 5 public comment periods, refer to the Wave 4 Measure Development Public Comment Summary Report (PDF, 839KB) (https://www.cms.gov/files/document/wave-4-public-comment-summary.pdf) and the Wave 5 Measure Development Public Comment Summary Report (PDF, 692 KB) (https://www.cms.gov/files/document/wave-5-public-comment-summary-report.pdf).

during the initial meeting and refine the measures prior to national field testing. After the national field test from February 1, 2024, to March 14, 2024, Acumen convened the workgroups for a Post-Field Test Refinement (PFTR) Webinar to continue measure specification and refinement discussions in March 2024. For Wave 6, all workgroup meetings were held virtually.

Movement Disorders PFTR Webinar, March 26, 2024

This meeting summary document outlines the purpose, discussion, and recommendations from the Movement Disorders PFTR Webinar. Section 1 provides an overview of the webinar goals and process. Section 2 summarizes the discussion and recommendations from the workgroup. Appendix A provides an overview of the chronic condition cost measure framework.

1. Overview

The goals of the Movement Disorders PFTR Webinar were the following:

(i) Review feedback on the measure from the national field test
(ii) Provide input to specify the cost measure for potential use in MIPS that can accurately distinguish between good and poor performance among clinicians in terms of cost efficiency
(iii) Consider results of empirical analyses and the Person and Family Partner (PFP) findings
(iv) Provide input on defining the patient cohort, accounting for sub-populations to ensure that the measure allows for meaningful clinical comparisons, and identifying clinically related services

The meeting was held online via webinar and attended by 13 of the 15 workgroup members. The webinar was facilitated by Acumen moderator, Heather Litvinoff. The Movement Disorders workgroup chair was Chloe Slocum, who also facilitated meeting discussions. One PFP, Patricia Chavez, attended the webinar to discuss and address questions regarding the PFE survey findings. The MACRA Episode-Based Cost Measure Workgroup Composition List contains the full list of members, including names, professional roles, employers, and clinical specialties.[3]

All interested parties beyond the workgroup members had access to a public dial-in number to observe the meeting as part of Acumen's continued effort to increase the transparency of the measure development process.

Prior to the webinar, workgroup members were provided with information and materials to inform their meeting discussions. This includes the meeting agenda, slide deck, and a summary of all the field testing feedback received for the draft measure. Also, workgroup members received the investigations described in Table 1 below.

Table 1: Workgroup Webinar Investigations

Investigation	Description
Sub-Population Analysis	• Provides data on the frequency and cost associated with a set of sub-populations informed by public comments received, prior workgroup discussions, and deliberations among the Acumen clinical team • Useful for discussion regarding accounting for patient heterogeneity

[3] CMS, MACRA Episode-Based Cost Measures Wave 6 Clinician Expert Workgroup Composition (Membership) List (PDF, 207 KB) (https://www.cms.gov/files/document/wave-6-measure-specific-workgroup-composition-list.pdf).

Investigation	Description
Service Utilization over Time Analysis	• Provides data on the top 200 most frequent services for each claim setting across episodes for the draft version of the measure along with various metrics regarding those services (e.g., share of episodes with that service, average cost of the service per episode, share of attributed clinicians who furnished the service) • Useful for discussion regarding identifying clinically relevant services

After the webinar, workgroup members were sent a recording of the webinar and polled on their preferences to ensure the measures are developed based on well-documented input. Based on similar meeting discussion practices, the threshold for support was >60% consensus among poll responses. This document summarizes the workgroup members' input from both the discussion as well as the polls.

This meeting was convened by Acumen as part of the measure development process to gather expert clinical input; as such, these are preliminary discussions and materials, which don't represent any final decisions about the measure specifications or MIPS.

2. Summary of Sessions and Discussion

This section is organized based on meeting sessions and describes workgroup member discussions and recommendations. The first sub-section summarizes the PFP findings discussed during the webinar. The remaining sub-sections describe workgroup member discussions and recommendations on defining the patient cohort, accounting for patient heterogeneity, and identifying clinically related services, respectively. The final sub-section provides an overview of the next steps for the measure development process.

2.1 Person and Family Partner (PFP) Findings and Discussion

During field testing, we gathered input from 15 comments, including PFPs, through the PFE Field Testing survey on the Movement Disorders measure. During the webinar, a PFP shared these findings and fielded questions from workgroup members.

PFPs identified a wide range of clinicians providing movement disorders care, such as family practitioners, nurse practitioners, neurologists, physical therapists (PTs), physician assistants (PAs), and cardiologists. The diversity of specialties involved in their care required effective care coordination, which was generally led by family members. Still, a few PFPs reported having no dedicated care team. For those that did have a clinician performing care coordination, this was primarily conducted by neurologists or primary care providers (PCPs).

PFPs emphasized the benefits of infusions, injections, physical therapy, occupational therapy, durable medical equipment (DME), and massage therapy. Medications and complementary care, such as acupuncture, represented a significant portion of their care and their out-of-pocket costs. PFPs also expressed a preference for home and community-based services over institutional care. Finally, PFPs mentioned palliative care and hospitalizations as results of an exacerbation in their condition.

Regarding barriers to care, PFPs reported difficulties in accessing non-procedural care, such as timely physical therapy. Many PFPs also noted transportation needs and issues getting referrals as large barriers to accessing care. PFPs also expressed the desire to get additional resources, such as bilingual services or informational materials on pain management and long-term care.

2.2 Defining the Patient Cohort

Acumen reviewed the methodology for constructing an episode-based cost measure, including the steps for defining the patient cohort. Cost measures for chronic conditions aim to identify a longitudinal patient-clinician relationship (i.e., trigger an episode of care for that condition) using the presence of related service and diagnosis codes on claims billed by the same clinician group (as identified by their Taxpayer Identification Number [TIN]). The steps for defining the patient cohort are described in Steps 1-4 of Table A1 in Appendix A. The workgroup discussed these categories of service and diagnosis codes in the context of what patient and clinician populations they would capture and to what degree they would reliably indicate an ongoing care relationship. Acumen asked the workgroup to review the triggering methodology, as well as the draft services and diagnoses, to discuss how the draft specifications may be improved.

Following the SAR Webinar, the workgroup voted to include G23 International Classification of Diseases, Tenth Revision (ICD-10) codes for "Other Degenerative Diseases of Basal Ganglia" in the Parkinson's and Related Conditions sub-group. They also voted to risk-adjust for G23 codes to further account for patient heterogeneity between these patients and Parkinson's patients. During the PFTR webinar, the workgroup revisited this topic, as some members anticipated that these conditions would be costlier, rarer, and more heterogeneous than Parkinson's. They were interested in seeing if these sub-populations performed differently. The preliminary results showed that risk-adjusting played a significant part in neutralizing costs for Other Degenerative Diseases of Basal Ganglia, which performed similarly to the measure's overall population after risk adjustment. These numbers reassured some panelists that such patients performed more similarly to Parkinson's than they initially envisioned.

Acumen also revisited the workgroup's decision to include a medication prescribing attribution requirement to the measure, which would ensure that clinicians are only attributed a Movement Disorders episode if they prescribe at least 2 condition-related medications to 2 different patients during the current plus prior performance period (see Step 4 in Table A1 of Appendix A). Including a medication prescribing attribution requirement would exclude some clinicians from the attribution logic, such as rehabilitation providers, because they don't prescribe medications. In response, commenters were split on whether PTs, occupational therapists (OTs), and speech-language pathologists (SLPs) were truly responsible for the management of movement disorders care. The workgroup reviewed numbers on the impact of the medication prescribing attribution check, which kept almost 30,000 episodes from being attributed to PTs, OTs, and SLPs combined. They also saw that these clinicians made up a higher portion of billing for the episodes in which they were present. Nonetheless, the workgroup was concerned that attributing the measure to rehabilitation clinicians would more heavily impact therapists billing in private practices, as therapists that bill through facilities or their own TIN-National Provider Identifiers (NPIs) aren't captured in the measure.

Key Takeaways from Discussion and/or Polls for Defining the Patient Cohort:

- Members were in favor of including "Other Degenerative Diseases of Basal Ganglia" in the Parkinson's and Related Disorders sub-group, provided that they're risk-adjusted.
- Members recommended keeping the medication prescribing attribution requirement to limit attribution to prescribing clinicians.

2.3 Accounting for Patient Heterogeneity

Members engaged in a detailed discussion about how to account for patient heterogeneity among various sub-populations within the Movement Disorders episode group. Sub-populations refer to patient cohorts as defined by their pre-existing conditions and other patient

characteristics. Acumen described the methods for accounting for patient heterogeneity, and those are described in Table 2 below.

Table 2: Methods for Accounting for Patient Heterogeneity

Method	Description
Sub-Group	• If applicable, we may stratify the patient population into mutually exclusive and exhaustive sub-groups to define more homogenous patient cohorts. • Sub-grouping is a method that's intended for when we would want to compare episodes only with other similar episodes within the same sub-group. • This approach is used when sub-groups are very different from one another, and each sub-group requires its own risk adjustment model. • Since each sub-group will have its own risk adjustment model, the size of each sub-group should be sufficiently large.
Risk-Adjust	• We may define covariates in the risk adjustment model for the measure. • Risk adjusting is a method to account for the case-mix of patients and other non-clinical characteristics that influence complexity. It's meant to be used for sub-populations that make up a large share of patients who have a characteristic that's outside of the attributed clinician's reasonable influence. • Risk-adjusted cost measures adjust observed episode spending to an expected episode spending (predicted by a risk adjustment model).
Exclude	• We may identify certain measure exclusions. • Excluding is a method in which we exclude certain patients or episodes to address issues with patient heterogeneity. This approach should be used when the sub-population affects a small, unique set of patients in which risk adjustment wouldn't be sufficient to account for their differences in expected cost.
Monitor for Further Testing	• We may monitor certain sub-populations for further testing. • Monitoring for further testing is an option for flagging certain sub-populations that the workgroup may revisit later during measure development upon review of further data. This approach is best used when the workgroup requests additional data or information on a sub-population to discuss the appropriate method for meaningful clinical comparison.

After Acumen provided a description of each method and presented analytic data on sub-populations, workgroup members discussed the patient sub-populations and their preferences for how to address them. Information about these methods is also described in Steps 3, 6, and 7 of Table A1 in Appendix A.

Based on the workgroup's input from previous webinars, the Movement Disorders measure didn't exclude any variables beyond the standard exclusions implemented in all episode-based cost measures, such as episodes ending in death, episode windows shorter than 1 year, and others (see Step 6 in Table A1 of Appendix A). During field testing, some commenters suggested excluding patients in hospice care, spinal cord injury patients, and Lewy Body Dementia patients. The measure's risk adjustment model already includes spinal cord injury and Lewy Body Dementia patients as part of Hierarchical Condition Category (HCC) variables, and hospice care is monitored. The workgroup discussed whether these sub-populations should continue to be included in the measure. Based on Acumen's preliminary results, the members saw that risk adjustment ensured that all variables had lower mean risk-adjusted costs compared to overall risk-adjusted costs, suggesting exclusions may not be appropriate for these sub-populations.

Commenters also suggested alterations to the current risk adjustment model. The workgroup discussed ways to account for the past use of neurosurgical procedures in the measure, such as Deep Brain Stimulators (DBS) or intrathecal pumps. For instance, one member noted that an appropriate length of the lookback period for identifying patients with history of DBS or pump implantation could be difficult to determine, as patients could have gotten implants many years prior to the episode start date. Acumen tested a longer lookback period of 365 days for past use

of DBS and intrathecal pumps, and found that the mean risk-adjusted costs for a 365-day lookback period were higher than the mean risk-adjusted costs for a 120-day lookback period.

The workgroup also discussed how to appropriately account for DBS and intrathecal pump procedures performed during the episode, as they emphasized the importance of not disincentivizing their use in the measure. Based on the workgroup's discussion and votes, Acumen will test the impact of including risk adjustment variables for neurosurgical procedures during the episode, not including the costs of neurosurgical procedures in the episode, or excluding patients who receive neurosurgical procedures during the episode. Acumen will review the findings with CMS to decide on an approach.

The workgroup also discussed how to account for Social Risk Factors (SRFs) in the measure, as one comment recommended risk-adjusting for Social Determinants of Health (SDOHs). Workgroup members reviewed different methods of accounting for SRFs, such as looking at race and ethnicity, SDOHs, ZIP codes, and a patient's dual Medicare and Medicaid enrollment status. Acumen explained that SDOHs aren't routinely and consistently coded on claims, and thus, don't qualify as reliable variables for estimating SRFs. Measure testing showed that dual status is the most consistent predictor of episode costs across sub-groups. As such, the Movement Disorders measure uses dual status as an SRF indicator.

Key Takeaways from Discussion and/or Polls for Accounting for Patient Heterogeneity:

- Members recommended excluding spinal cord injury patients but weren't in favor of excluding Lewy Body Dementia patients.
- Since the workgroup didn't reach consensus on excluding hospice care patients, they won't be excluded from the measure.
- The workgroup was in favor of adding stereotactic radiosurgery and microvascular decompression as additional risk-adjustors. Given the small sample size of each variable and their impacts on the risk adjustment model, these sub-populations will be excluded from the measure instead.
- Since the workgroup didn't reach consensus on risk-adjusting for history of DBS, history of intrathecal pump, craniotomy, or rhizotomy, these won't be included in risk adjustment.
- Alternatively, members provided recommendations for addressing neurosurgical procedures that happen during the episode. Based on updated testing results, DBS and intrathecal pump procedures during the episode will be included in the risk adjustment model.

2.4 Identifying Clinically Related Services

Acumen described the purpose of service assignment so that members could discuss which services associated with the attributed clinician's role in managing the patient's care should be included in the cost measure. These assigned services should be inclusive enough to identify a measurable performance difference between clinicians but also not introduce excessive noise. Episode-based cost measures aim to only include clinically relevant costs whose occurrence, intensity, and/or frequency are within the reasonable influence of the attributed clinician. Service assignment can be an effective form of adjusting for patient risk by omitting unrelated costs not furnished for Movement Disorders. Information about identifying clinically related services is also described in Step 5 of Table A1 in Appendix A.

Acumen asked for feedback on whether the following preliminary service assignment categories and examples capture both standard treatment and services provided to treat complications or other consequences of care:

- Routine provider visits, lab/imaging services
- Physical/occupational/speech therapy services, durable medical equipment
- Pulmonary services, sleep-related studies, nutrition services, gastrointestinal services, behavioral health services
- Part D medications, infusion therapy, deep brain simulation, drug-administration intrathecal pumps
- Urinary tract infection, pressure injuries, pneumonia, medication toxicity syndromes, subdural hematomas, contractures, hip fractures and joint replacements, other fall-related care
- Related inpatient hospitalizations, related post-acute care, other home health services, other emergency department visits

In a previous poll, the workgroup reached consensus on including hip and femur fractures, which were added to the current service assignment specifications. They didn't, however, reach a consensus on whether to include other fractures (e.g., wrist), sepsis, and nutritional status as clinically related services. During the PFTR Webinar, the workgroup expressed a preference for treating all fractures similarly – that is, including all types of fractures or not adding any of them. The workgroup also went over field testing comments that expressed concern with the inclusion of craniotomy, DBS, and decompression of peripheral nerves, as the commenters believed that including surgical procedures in service assignment could disincentivize their use. The workgroup emphasized the importance of appropriately adjusting the costs of such procedures to include them in the measure, as they're rarely assigned but represent important costs. Finally, one workgroup member also recommended including new 2024 rehabilitation codes in the measure, such as training and remote therapy services.

Key Takeaways from Discussion and/or Polls for Identifying Clinically Related Services:

- Members recommended including hip and femur fractures, sepsis, hospitalizations for metabolic nutritional status, DBS, as well as training and remote therapy codes as clinically related services. They didn't reach consensus on including other fractures (e.g., wrist), which won't be included in service assignment.
- The workgroup wasn't in favor of adding craniotomy and decompression of peripheral nerves as clinically related services.

2.5 Measure Name and Next Steps

As a final discussion item, Acumen revisited the question from previous webinars of renaming the measure. The workgroup previously reached consensus on renaming the measure to "Progressive Neurological Disorders Affecting Movement." Members considered concerns brought up during field testing that the proposed name could suggest that the measure encompasses additional neurological disorders, such as dystonia or multiple system atrophy. As an alternative, some members expressed support for renaming the measure to "Parkinson's Syndromes, Multiple Sclerosis, and Amyotrophic Lateral Sclerosis."

Acumen then provided a wrap up of the discussion and an overview of the next steps. After the meeting, Acumen distributed the PFTR Webinar Poll to gather input from members on the discussions held during the webinar. Acumen will operationalize input for the measure specifications based on PFTR Webinar discussion and poll results and will follow up with workgroup members with more information about the final steps in the measure development process.

Key Takeaways from Discussion and/or Polls for Renaming the Measure:

- The workgroup recommended renaming the measure to “Parkinson's Syndromes, Multiple Sclerosis, and Amyotrophic Lateral Sclerosis.”

APPENDIX A: CHRONIC CONDITION COST MEASURE FRAMEWORK

The table below provides an overview of the chronic condition episode-based cost measure framework.

Table A1. Chronic Condition Cost Measure Framework

Step	Description

Step 1: Trigger – Identify a Clinician-Patient Relationship	• Trigger logic looks for a pair of services billed by the same clinician group (identified by their TIN) to identify a clinician-patient relationship. The time period between the 2 services that constitute a trigger event is referred to as the 'trigger window' and reflects how often the clinician group sees the patient.
	• A **trigger event** consists of (i) a trigger claim, and (ii) a confirming claim.
	  ○ A **trigger claim** is an outpatient evaluation and management (E&M) code with a relevant diagnosis
	  ○ A **confirming claim** is either another outpatient E&M code with a relevant diagnosis, or a condition-related Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) code with a relevant diagnosis

Step 2: Reaffirm – Identify the Total Length of Care	• Once a clinician-patient relationship is identified, this starts a period of time when the TIN is measured on related costs (i.e., 'attribution window'). • The attribution can be extended if we continue to see that the TIN is providing care for the patient for this condition (as identified by 'reaffirming claims'). The same trigger and confirming codes are typically used to reaffirm the clinician-patient relationship.

Step 3: Define an Episode During Which Cost will be Assessed	• An 'episode' is a segment of care that allows clinicians to be assessed in a measurement (or performance) period.
	• An episode window length is one year at a minimum. Episodes are assessed in the measurement period in which they end and only include days not previously measured in preceding measurement periods.
	  ○ The episode window length may vary depending on the length of the total relationship between a patient and clinician group ('total attribution window'), and the data that hasn't been assessed in preceding measurement periods.
	  ○ Clinicians or clinician groups are measured on a patient at the end of the calendar year if there are 365 days' worth of claims data that hasn't previously been assessed or when the total attribution window ends, ensuring costs are only assessed once.
	• Once an episode window is defined, if applicable, the episode is placed into one of the episode sub-groups to enable meaningful clinical comparisons.

Step 4: Attribute the Episode to the Clinician Group and Clinician(s)	• Attribute episode to the TIN that billed the trigger services (trigger claim and confirming claim) for the 'total attribution window.'
	• Attribute episode to the clinicians [identified by their TIN-National Provider Identifier (TIN-NPI)] within the attributed TIN that played a substantial role in the patient's care:
	  ○ Billed at least 30% of outpatient E&M codes with a relevant diagnosis and/or condition-related CPT/HCPCS codes with a relevant diagnosis
	• The TIN-NPI must also meet particular requirements to ensure that no costs are assigned to the attributed TIN-NPI prior to seeing the patient and that we are attributing episodes to clinicians who manage a patient's chronic care. The TIN-NPI must have:
	  ○ Check #1: Provided condition-related care to the patient prior to or on the episode start date (to ensure that clinicians are attributed episodes after they met the patient)
	  ○ Check #2: Prescribed at least 2 condition-related medications to 2 different patients during the current plus prior performance period (to ensure that attributed clinicians are actually involved in providing ongoing chronic care management)
	  ▪ This check is only used in measures where the use of prescriptions is informative about the nature of care that the clinician provides. When some of the types of clinicians that manage the condition don't always prescribe the relevant medication (e.g., clinicians that can't prescribe), a chronic condition cost measure wouldn't use this check.

Step	Description
Step 5: Assign the Cost of Clinically Related Services	• Measures include only the costs for clinically related services, rather than all costs within the episode. • Clinically related services include treatment, monitoring, complications, and other services where the attributed clinician has reasonable influence on occurrence, frequency, and/or intensity. • Costs are payment standardized to remove variation due to geographic region or provider-specific adjustments. • These are identified through medical service codes and diagnosis codes. The measure calculates the cost of these specific services observed during the episode window.
Step 6: Apply Measure Exclusions	• Exclusions remove unique groups of patients or episodes from cost measure calculation in cases where it may be impractical or unfair to compare the costs of caring for these patients to the costs of caring for the cohort at large.
Step 7: Risk-Adjust Episode Cost	• Risk adjustment predicts the expected cost of an episode by adjusting for factors outside of the clinician's control. • The risk adjustment model includes many variables the workgroup will discuss throughout development. As a starting point, we assess the following: (i) Hierarchical Condition Categories (HCCs) from the CMS-HCC Version 24 (V24) Risk Adjustment Model, which includes 86 HCCs, (ii) age variables, (iii) indicator variables, and (iv) interaction variables. • In addition, each measure may have tailored risk adjustors for factors specific to the condition. • If the cost measure has episode sub-groups, the risk adjustment model is run separately for each sub-group.
Step 8: Calculate the Measure Score	• The measure is calculated as the ratio of the observed cost (standardized to remove geographic and other differences) to the expected cost, averaged across all episodes attributed to the provider. • Longer episodes are weighted more heavily than shorter ones to ensure fair comparisons; a scaled approach is used to calculate observed and expected costs. • The average ratio of observed to expected costs per provider is then translated into a dollar amount as the provider's measure score.

Please contact **Acumen MACRA Clinical Committee Support** at macra-clinical-committee-support@acumenllc.com if you have any questions. If you're interested in receiving updates about MACRA Episode-Based Cost Measures, please complete this Mailing List Sign-Up Form to be added to our mailing list.